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| Initial Client Consult Form | | | | | | | | | | | |
| First Name | | | Last Name | | Middle Name | | | | Date of Birth | | Today’s Date |
| Street Address | | | | | City | | | | State | Zip | Gender |
| Phone | Alternate Phone | | | | E-mail Address | | | | Height | | Weight |
| Health History | | | | | | | | | | | |
| Chief Complaints (and how long you have had them):  Current Diagnoses: | | | | | | | | | | | |
| Treatment History (What have you tried, and how well did it work – Use separate page if needed):  Any testing for celiac disease? Results?  Do you have a history of diagnosed or suspected Eating Disorders? (Anorexia Nervosa or Bulimia)  Do you have a history of/suspected addictions? (Food, drug, alcohol, behavioral): | | | | | | | | | | | |
| What medications (prescription or over-the-counter) do you currently take? | | | | | | | | | | | |
| What supplements do you currently take? | | | | | | | | | | | |
| Do you have allergies of any kind (in other words, cat, dust, pollen, food, meds, etc.)? Please list: | | | | | | | Are there any foods that “don’t agree” with you? | | | | |
| Eating Habits/Lifestyle Considerations | | | | | | | | | | | |
| What is your occupation? | | | | How often do you cook from scratch? | | | | How often do you eat out? | | | |
| Do you tend to skip meals? | | Do you ever eat for comfort? | | | | What situation(s) cause you to eat for comfort? | | | | | |
| How do your health problems interfere with your life? | | | | What foods (if any) do you crave? | | | | Are there any foods you could not give up for 2 weeks? | | | |
| On a scale from 1-10, how badly are these problems affecting your life? | | | | | | | | | | | |
| On a scale from 1-10, how committed are you to getting better? | | | | | | | | | | | |
| Do you have “support” from family/friends? Who? | | | | | | | | | | | |
| What are your main health concerns/treatment goals? | | | | | | | | | | | |
| Office Use Only- Notes | | | | | | | | | | | |
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